Complete Summary

GUIDELINE TITLE

Surgical management of hemorrhoids.

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Surgical management of hemorrhoids. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p. [1 reference]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Internal hemorrhoids
- External hemorrhoids
- Acute complications of internal hemorrhoids (prolapse) and external hemorrhoids (thrombosis)

GUIDELINE CATEGORY

Diagnosis
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Gastroenterology
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs.

TARGET POPULATION

Adult patients with enlarged and symptomatic hemorrhoids.

INTERVENTIONS AND PRACTICES CONSIDERED

Treatment of hemorrhoids:

1. Conservative therapy for patients with chronic symptoms: stool bulking and topical therapy with ointments or suppositories
2. Outpatient surgical treatment to relieve symptoms if conservative treatment fails (e.g. infrared coagulation, local injection, rubber banding)
3. Laser or traditional surgical hemorrhoidectomy for symptomatic patients with stage III or IV hemorrhoids
4. Narcotics for pain relief
5. Excision of residual hemorrhoidal tissue (i.e. external anal tags) during an office visit following episode of an acute hemorrhoidal thrombosis

MAJOR OUTCOMES CONSIDERED

- Relief of pain, bleeding, local protrusion
- Symptom recurrence

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Please note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

Treatment

Initial therapy for chronic symptoms of hemorrhoidal disease should be conservative, including stool bulking and topical therapy with ointments or suppositories. Outpatient surgical treatment is appropriate if conservative treatment fails and the patient desires relief of symptoms. Operative treatment is reserved for symptomatic patients with Stage III or IV hemorrhoids. If the patient has evidence of anemia, full colonic examination is indicated and more aggressive treatment necessary.

In patients with Stage I, II, or III disease, local treatment is appropriate in the form of infrared coagulation, local injection, or rubber banding. Stage I and II diseases are effectively treated by any of these modalities, with resolution of symptoms in at least 90% of patients. Cryotherapy should be avoided because of excessive post-treatment symptoms. Stage III disease is probably best treated by hemorrhoidal banding to remove redundant tissue, but long-term resolution of symptoms is likely in only 70% of these patients. Stage IV disease requires surgical intervention, which is associated with long-term resolution of symptoms in 95% of patients. The term "laser hemorrhoidectomy" refers to excision of hemorrhoidal tissues using a laser rather than standard surgical instruments, but is a surgical procedure nonetheless.

Symptoms may also arise from residual hemorrhoidal tissue after an episode of acute thrombosis of external hemorrhoids. These external anal tags may prevent proper cleansing and can be excised during an office procedure if symptoms warrant.

Qualification for Performing Surgery for Hemorrhoids

Surgeons who are certified or eligible for certification by the American Board of Surgery, the American Board of Colon and Rectal Surgery, the Royal College of Physicians and Surgeons of Canada, or their equivalent should perform hemorrhoidectomy. These surgeons have undergone at least 5 years of surgical training after medical school and, in most instances, are qualified to perform hemorrhoidectomy. In addition to the standard residency training, qualifications should be based on training, experience, and outcomes.
Adequate training in the management of anorectal disease is important to perform this procedure. The surgeon must be able to treat complications (bleeding,

infection, and urinary retention) should they occur. Therefore, surgical training is necessary to manage hemorrhoidal disease.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Following local treatment, symptoms of local protrusion and bleeding should be eradicated. The risk of recurrent symptoms following local treatment varies with the extent of local disease, with a 10% recurrence rate for Stage I (bleeding only, no prolapse) and Stage II disease (prolapse that reduces spontaneously, with or without bleeding), and 30% for Stage III disease (prolapse that requires manual reduction, with or without bleeding). Hemorrhoidectomy carries a 5% risk of recurrent symptoms.

POTENTIAL HARMS

Risks of treatment include bleeding and infection. The risk of bleeding after local therapy is about 1%. The risk of infection after local treatment is unknown, but is certainly less than 1%. Local pain is a common side effect of local treatment. Pain after banding and injection typically lasts 24-36 hours, and continued pain requires medical attention. Excessive pain after treatment is due to sphincter spasm, and may render urination difficult. Urinary retention is an occasional symptom of occult sepsis.

Bleeding and infection are greater risks after open hemorrhoidectomy, but occur less than 5% of the time. Pain after open hemorrhoidectomy is significant and generally requires narcotics for relief. The fear of bowel movement because of pain may lead to fecal impaction in a few patients. There may be subtle changes in continence of gas or liquid stool following local treatment or surgery, but they are rarely socially significant. Injury to the anal sphincter muscle is a recognized risk, but is extremely rare in experienced hands. Anal incontinence is a rare complication of surgery for hemorrhoidal disease.

Subgroups Most Likely to be Harmed:

Patients with co-morbid conditions such as diabetes, HIV, or heart disease increase the risks of local treatment, but do not alter the type of complications.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines have been written by the Patient Care Committee of the Society of Surgery of the Alimentary Tract (SSAT). Their goal is to guide PRIMARY CARE physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the range of acceptable clinical practice and should not be construed as a standard of care. These Guidelines require periodic revision to ensure that clinicians utilize procedures appropriately but the reader must realize that clinical judgement may justify a course of action outside of the recommendations contained herein.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract. Surgical management of hemorrhoids. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p. [1 reference]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2000)

GUIDELINE DEVELOPER(S)

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Surgery of the Alimentary Tract, Inc.

GUIDELINE COMMITTEE

Patient Care Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Committee Members: Thomas R Gadacz, MD (Chairman); L William Traverso, MD; Gerald M Fried, MD; Bruce Stabile, MD; Barry A Levine, MD.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

Please note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available from the Society for Surgery of the Alimentary Tract, Inc. Web site.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on March 28, 2000. The information was verified by the guideline developer as of May 30, 2000.

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